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No. 93-348

In the Supreme Court of the United States

OCTOBER TERM, 1993

PGDH LIQUIDATING TRUST, ETC., PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Various provisions of the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, altered Medicare rules to require that all Medicare reimbursement for the nonphysician component of certain ancillary services be made directly to the hospital under Part A of the Medicare Program, but Section 602(k) of that statute included a transition provision that allowed certain outside providers who received a waiver from the Secretary to continue to bill the Secretary directly under Part B of the Medicare program for those services. 97 Stat. 165-166. If providers did so, however, payments made under Part A to the hospital where the services were rendered were reduced by the amount of the billings for such services under Part B. The question presented is whether the reduction in Part A compensation to the hospital based on the Part B billings is limited to the amount of Part A compensation sought by the hospital for such services.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 2-18) is unpublished, but the judgment is noted at 993 F.2d 228 (Table). The opinion of the district court (Pet. App. 19-31) is unreported. The opinion of the Provider Reimbursement Review Board (Pet. App. 32-61) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on May 7, 1993. A petition for rehearing was denied on June 2, 1993. Pet. App. 62-63. The petition for a writ of certiorari was filed on August 31, 1993. The

jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioner is successor-in-interest to Prince George's Doctors' Hospital (PGDH), a Maryland hospital. This case involves a challenge by petitioner to a final decision of the Secretary of Health and Human Services regarding the amount of Medicare reimbursement due PGDH during cost reporting periods ending June 30, 1984, and May 31, 1985.[1]

1. Subchapter XVIII of Chapter 7 of Title 42, 42 U.S.C. 1395-1395ccc (1988 & Supp. III 1991), establishes Medicare, a two-part health insurance program that reimburses the cost of certain medical services provided to eligible elderly and disabled beneficiaries. Part A of Medicare, 42 U.S.C. 1395c to 1395i-4 (1988 & Supp. III 1991), provides reimbursement for certain hospital and post-hospital medical services rendered to beneficiaries. Persons are covered by Part A if they are eligible for monthly social security benefits. 42 U.S.C. 1395c (Supp. III 1991). Payments are made by private organizations (usually insurance companies) that act as fiscal intermediaries under contract with the Secretary. 42 U.S.C. 1395h (1988 & Supp. III 1991). Payments under Part A generally are made under a prospective payment system, which pays the hospital a fixed price per discharge based on the

[1] On June 1, 1985, substantially all the assets of PGDH were sold to a publicly held corporation and the remaining assets were transferred to petitioner, a liquidating trust formed by the hospital's shareholders. The challenge to the reimbursement amounts was pursued by petitioner as successor-in-interest to the hospital. See Pet. App. 33.

diagnosis-related group (DRG) in which the patient's medical condition fell. 42 U.S.C. 1395ww(d) (1988 & Supp. III 1991).

The Secretary is authorized to allow a State to opt out of the federal payment system if the State establishes its own reimbursement control system, 42 U.S.C. 1395ww(c) (1988 & Supp. III 1991), and the Secretary had entered into such an agreement with the State of Maryland for the relevant years, see Pet. App. 8-9. Under that system, participating Maryland hospitals are paid for covered services to Medicare patients according to a prospective payment methodology established by Maryland's Health Services Cost Review Commission (HSCRC).

Part B of Medicare, 42 U.S.C. 1395j to 1395w-4 (1988 & Supp. III 1991), is a voluntary program covering physicians' charges and other medical services. Coverage under Part B, however, is available only to persons who enroll and pay monthly premiums. Part B payments reimburse beneficiaries for a portion of the charges they incur for certain medical and other health services. 42 U.S.C. 1395k (1988 & Supp. III 1991). As with Part A, payments are made by private entities (typically insurance carriers) acting on behalf of the Secretary. 42 U.S.C. 1395u (1988 & Supp. III 1991). Under applicable regulations, payments generally are based on reasonable charges, as determined by the carrier, which must consider factors such as the physician's actual charge, the customary charges for similar services generally made by the physician, and the prevailing charges in the locality for similar services. 42 C.F.R. 405.502 (1985).

2. Medicare originally permitted a hospital to "spin off" or "unbundle" the nonphysician component

of ancillary services such as radiology and physical therapy. Hospitals that "unbundled" those services would allow the "technical" or nonphysician component of those services to be provided on their premises by departments leased from the hospital by third parties; this allowed the third parties to charge Medicare beneficiaries for those services under Part B of Medicare. See Pet. App. 5. In 1983, however, Section 602 of the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 163-166, ended that practice. Section 602(e) barred any payment under Part A or Part B of Medicare for nonphysician services that "are furnished to an individual who is an inpatient of a hospital by an entity other than the hospital [with exceptions not relevant here]." 97 Stat. 163 (codified as amended at 42 U.S.C. 1395y(a)(14) (Supp. III 1991)). Similarly, Section 602(f)(1) provided that a hospital would be eligible to participate in the Medicare program only if the hospital agrees "to have all items and services (other than physicians' services * * *) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under [the Medicare program], furnished by the hospital [with exceptions not relevant here]." 97 Stat. 164 (codified as amended at 42 U.S.C. 1395cc(a)(1)(H) (Supp. III 1991)).

Apparently out of a concern that a rapid transition to the new regime might endanger the quality of patient care in hospitals with extensive unbundling of services, Congress included a transition provision allowing the Secretary to waive the new limitations on unbundling of services for cost reporting periods

beginning before October 1, 1986. That provision, Section 602(k), stated:

> The Secretary of Health and Human Services may, for any cost reporting period beginning prior to October 1, 1986, waive the requirements of [the new unbundling restrictions discussed above] in the case of a hospital which has followed a practice, since prior to October 1, 1982, of allowing direct billing under [P]art B of [Medicare] for services (other than physicians' services) so extensively, that immediate compliance with those requirements would threaten the stability of patient care. Any such waiver shall provide that such billing may continue to be made under [P]art B * * * but that the payments to such hospital under [P]art A * * * shall be reduced by the amount of the billings for such services under [P]art B.

97 Stat. 165-166.[2]

In September 1983, the Secretary issued regulations that required a hospital seeking a waiver under Section 602(k) to show that before October 1, 1982, a "significant proportion of all ancillary services furnished to the hospital's inpatients" had been furnished by outside suppliers and billed by those suppliers under Part B. 42 C.F.R. 489.23(c)(1) (1985). Under the regulations, a hospital could meet that requirement if the hospital's inpatients received at least three distinct types of ancillary services primarily from outside suppliers, and if the reasonable charges for nonphysician services provided by out-

[2] The provision appears as a note to 42 U.S.C. 1395y in the 1988 edition of the United States Code.

siders were at least 125% of the reasonable cost of nonphysician ancillary services furnished directly by the hospital. 42 C.F.R. 489.23(c)(2) (1985).

3. PGDH requested a waiver on August 22, 1983. The request could not be evaluated under the Secretary's regulations because, among other things, it included "unitary" bills from PGDH's outside suppliers, which did not separate the physician and nonphysician components of the charges. Because the request did not enable the Secretary to determine the cost of the nonphysician ancillary services billed to the hospital by outsiders, the Secretary was unable to determine whether the request met the 125% test established by the Secretary's regulations. Eventually, PGDH provided two alternate Schedules separating the physician and nonphysician components of those charges. Schedule I was based on supplier-furnished estimates of the percentages of each supplier's annualized charges representing the nonphysician component of ancillary services provided to Medicare inpatients at PGDH. Schedule II estimated those percentages on the basis of statewide averages prepared by PGDH's consultants. The Secretary informed PGDH that it satisfied the 125% test under either schedule and asked PGDH to choose one schedule for purposes of determining the offset. PGDH chose Schedule II. The Secretary granted the waiver on December 30, 1983. See Pet. App. 9-10 & n.4.

4. Although the waiver allowed PGDH's suppliers to receive compensation under Part B of Medicare, the Secretary was not able to implement the offset against PGDH's Part A compensation, because PGDH was involved in litigation over the authority of

the Maryland HSCRC to set rates for the nonphysician component of ancillary services provided by outside suppliers. Accordingly, PGDH had not presented bills for those services under Part A against which the Secretary could offset the Part B billings. Because of that problem, a federal district court enjoined the Secretary from using the amounts paid to outside suppliers under Part B to offset payments to PGDH under Part A. The injunction was designed to expire automatically upon resolution of the dispute between PGDH and the HSCRC.[3] See Pet. App. 10.

In January 1985, the Maryland Court of Appeals upheld the authority of the HSCRC to set rates for the nonphysician component of ancillary services provided by outside suppliers. *Prince George's Doctors' Hospital, Inc.* v. *Health Services Cost Review Comm'n*, 486 A.2d 744. At that point, the federal court's injunction dissolved, and PGDH received retroactive Part A payments for the services in question, subject to an offset in the amount the Secretary already had paid to the suppliers for those services under Part B. Because the suppliers had submitted unitary bills that did not separate physician from nonphysician charges, the Secretary calculated the offset by using the percentages that PGDH had submitted in Schedule H. The Part A payments based on the HSCRC rates were lower than the charges the outside suppliers had made under Part B; hence, the offset of the Part B payments made to PGDH's outside suppliers resulted in PGDH's compensation under Part A being reduced by an

[3] The propriety of that injunction is not before the Court.

amount greater than the amount the Maryland HSCRC had allowed it to charge for the services. See Pet. App. 10-11.

5. Petitioner challenged the use of the Schedule II percentages in a proceeding before the Provider Reimbursement Review Board (PRRB), arguing that the HSCRC rates, rather than the Schedule II percentages, should have been used to determine the amount of Part B payment to the suppliers for the nonphysician component of the charges. After three days of hearings, the PRRB rejected PGDH's position. Pet. App. 32-61. The PRRB noted that PGDH had "elected to use the statewide averages reflected on Schedule II in order to assure its compliance with the 125 percent test," and accordingly reasoned that petitioner was "obviously locked-in to the same percentages for the purpose of computing the required offset of Part B billings." *Id.* at 59. The PRRB also stated that it is "extremely doubtful" that PGDH could have secured the waiver in the first instance if it had used the lower HSCRC rates as the basis for calculating the nonphysician component of the outside suppliers' ancillary services. *Id.* at 60.

6. Petitioner sought judicial review in the United States District Court for the District of Maryland pursuant to 42 U.S.C. 1395*oo*(f)(1), which provides for review in accordance with the Administrative Procedure Act. The district court upheld the Secretary's decision, Pet. App. 19-31, explaining that "[t]he thorough and carefully-reasoned decision of the [PRRB] is particularly suited to * * * deferential treatment," *id.* at 29. The court found unrefuted evidence that PGDH had agreed to use Schedule II for the offset calculation, because the terms of the waiver

specifically required that the proportion of nonphysician charges be consistent with the percentages in Schedule II. *Ibid.* The court also concluded that the PRRB properly rejected the use of HSCRC rates, because the HSCRC never enforced those rates against outside suppliers and PGDH probably would not have met the waiver requirements if those rates had been applied at the outset. *Id.* at 30. The district court acknowledged that the outside suppliers had violated the Secretary's regulations by submitting unitary bills, but held that the waiver imposed a duty on the hospital to enforce compliance with the regulation. *Ibid.* Finally, the district court rejected petitioner's claim that three other hospitals were treated more favorably in application of the offset provision, noting that the record showed that "the circumstances surrounding these other hospitals are easily distinguished from [those of] the hospital in this case." *Id.* at 31.

7. The court of appeals affirmed in an unpublished opinion. Pet. App. 2-18. The court started from the premise that the standard of review for a court evaluating the Secretary's interpretation of the Medicare Act is narrow: "Because the Medicare Act is 'among the most intricate [Acts] ever drafted,' APA principles of review require courts to give considerable deference to the Secretary's statutory interpretation unless that interpretation is clearly contrary to the plain and sensible meaning of the statute." Pet. App. 13 (quoting *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981); brackets and other citation and internal quotation marks omitted).

The court began its analysis of Section 602(k) by examining the "plain wording of the offset provision,"

Pet. App. 14, which required the Secretary to offset from Part A billings for nonphysician charges "the amount of the billings for such services under Part B." *Ibid.* (quoting Section 602(k), 97 Stat. 166). The court concluded that the language "mandates clearly and unequivocally" that the Secretary could not use HSCRC rates in determining the offset without having evidence that the suppliers actually sought Part B reimbursement at those rates. *Id.* at 15. Because the evidence in this case indicated that the outside suppliers never actually billed at the HSCRC rates for the nonphysician component of ancillary services, the Secretary "had to rely on other data to determine the appropriate amount" of the offset. *Ibid.* The court noted that the Schedule II percentages represented the only data available to the Secretary to compute the offset, because the suppliers had submitted unitary bills and because PGDH presented no evidence that the suppliers had billing rates different from those in Schedule II. *Ibid.* Moreover, because Part A payments under the prospective DRG formula are usually less than the reasonable charge payments under Part B, the fact that Section 602(k) requires Part A payments to be offset by Part B payments indicates that Congress recognized the possibility that a hospital's offset would not equal its Part A payments. *Id.* at 16 n.6.

The court of appeals also found that the Secretary's refusal to adjust the offset for PGDH despite doing so for The Carle Foundation Hospital, St. Mary's Hospital, and Rochester Hospital was not arbitrary or capricious. Pet. App. 16-17 & n.7. The Secretary had explained, with respect to the other three hospitals, that an adjustment was necessary because those

hospitals had received no payments under Part A for certain charges billed by outside suppliers under Part B. In contrast, PGDH did receive payment for those charges under Part A, albeit at a lower rate. Because that was a "reasonable distinction between PGDH and the other hospitals," *id.* at 17, the court of appeals held that the Secretary did not act arbitrarily or capriciously in refusing to adjust the offset for PGDH.

ARGUMENT

This case involves unique circumstances in the application of a statute that has no continuing effect, and the unpublished decision of the court of appeals is correct. No further review is warranted.

1. Section 602(k) provided for a one-time waiver allowing a few hospitals to phase in the 1983 changes in the Medicare reimbursement scheme for the nonphysician component of ancillary services. The Secretary has long since ceased to grant such waivers, which were effective only with respect to fiscal years beginning before October 1, 1986. Indeed, the Secretary has advised us that this case involves the only remaining dispute over application of the offset provision. Because only a handful of hospitals ever were granted a Section 602(k) waiver, it is not surprising that, in petitioner's own evaluation, this is "a substantive area in which there is virtually no case law," Pet. 19. The limited continuing effect of the question by itself strongly counsels against review by this Court.

2. Furthermore, the decision of the court of appeals was correct. Petitioner's lengthy discourse on the purpose and intent behind the statute fails to

consider the language Congress chose to effectuate that intent, which required "that the payments to such hospital under [P]art A * * * shall be reduced by the amount of the billings for such services under [P]art B." 97 Stat. 165-166. Read in context, that language necessarily requires the offset of an amount computed in one manner (nonphysician reasonable charges under Part B) from an amount computed in a completely different manner (prospective DRG costs under Part A). Thus, Congress necessarily contemplated the offset of unequal amounts. For the same reason, the language cannot plausibly be read to limit the amount of offset of nonphysician Part B billings to the total amount of the corresponding nonphysician portion of Part A reimbursement. In sum, the statute clearly prescribes the amount of the offset (the amount of the Part B billings); petitioner's argument that Congress should have prescribed a different amount (the Part B billings, but not to exceed the corresponding Part A billings) cannot be reconciled with the statute.

None of petitioner's contrary arguments warrants review by this Court. Petitioner first argues (Pet. 16-19) that the case affords an opportunity to "clarify," Pet. 19, the doctrine of administrative deference articulated in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). But petitioner offers no substantial support for its argument that the court gave "unwarranted deference" to the Secretary's interpretation of the statute. In particular, it never addresses the court of appeals' conclusion that because the "plain wording" of the statute required the Secretary to base the offset on the amounts actually billed by outside suppliers under

Part B, Pet. App. 14, it was appropriate for the Secretary to abjure reliance on the HSCRC rates that had never been used by or applied to the outside suppliers, *id.* at 15. That analysis is not inconsistent with *Chevron*.

Petitioner's argument (Pet. 19-23) that secondary materials indicate that the statute was designed to result in an approximately equal offset is similarly unpersuasive. As explained above, the fact that permissible Part A reimbursement generally would be lower than permissible Part B reimbursement indicates that Congress must have known that the corresponding offsets would be unlikely to be equal, and that the result frequently would be the same sort of offset as the one petitioner challenges here. See Pet. App. 16 n.6.

The court of appeals also properly rejected petitioner's argument (Pet. 23-26) that it was arbitrary and capricious for the Secretary to refuse to apply HSCRC rates in computing Part B nonphysician billings. As the court noted, Pet. App. 15-16, there was no evidence that the HSCRC rates ever were applied to the outside suppliers and thus those rates could not be said to reflect accurately the suppliers' actual billings for the nonphysician component of ancillary services. Without evidence that the HSCRC rates reflected the Part B billings, the Secretary could not have used those rates in applying the offset under Section 602(k), which, as stated above, was tied to the actual Part B billings of the outside suppliers. Moreover, it does not come well from PGDH to characterize it as arbitrary for the Secretary to rely on the allocation method that PGDH had submitted in order to qualify for the

waiver, especially when the allocation method PGDH urges now (use of the HSCRC rates) apparently would have resulted in denial of the waiver in the first instance.[4]

Finally, the court of appeals correctly rejected petitioner's contention (Pet. 28-30) that it was arbitrary and capricious for the Secretary to adjust the offset for three other hospitals but not for PGDH. As the court of appeals explained (Pet. App. 16-17), the offsets for the other hospitals were reduced because the Part B charges for their suppliers included charges for which the hospitals had neither sought nor received payments under Part A. The adjustments petitioner criticizes were made to prevent what the Secretary perceived as an anomaly: an offset for Part B charges for which Part A reimbursement was not sought. See *ibid.* By contrast, the dispute over the offset for PGDH concerned differences in the rate of payment for essentially the same services, where compensation was sought under both Part A and Part B.[5]

[4] The suppliers' violation of the Secretary's regulation by submitting unitary bills (on which petitioner relies at Pet. 25) does not change this analysis. As the district court pointed out, the terms of the waiver specifically required petitioner's predecessor (not the intermediary) to make the outside suppliers honor this obligation. See Pet. App. 30.

[5] Petitioner also argues (Pet. 26-28) that the Secretary improperly included outpatients in the computation of Part B billings to be offset against Part A payments. As petitioner explains (Pet. 27), the Secretary's decision on that ground rested on the decision of HSCRC to include those services in the rates for which petitioner was seeking reimbursement under Part A. Because petitioner was using those rates to seek reimbursement under Part A, the failure to offset the reimbursement sought by outside suppliers under Part B would

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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have resulted in double payment by the government. Petitioner offers no basis for supposing that the Secretary's resolution of that unusual issue warrants review by this Court.